

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04835 T

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County... Caroline  
 City or town... Denton Ind.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Ind. County... Caroline  
 City or town... Denton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name War \_\_\_\_\_

## 3. (a) FULL NAME

Ida Mae Chaffinch

## 3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widow

## MEDICAL CERTIFICATION

6. (b) Name of husband or wife... John Chaffinch; Prof.

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) July 12<sup>th</sup> 1874

8. AGE: Years 70 Months 8 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Smithville Ind.  
 (Town, county, and state)

10. Usual occupation... at home

## 11. Industry or business

12. Name... John Sutherland

13. Birthplace Del.

14. Maiden name... Lucile Marshall

15. Birthplace Maryland

16. Informant Blanche Klettch

Address Denton Ind.

17. Buried Date thereof 5-9-45  
 (Burial, cremation, or removal. Which) (month-day-year)

Cemetery or crematory Denton Cemetery

Location Denton Ind.

18. Funeral director J. Virgil Moore & Son

Address Denton Ind.

19. 5/7 19 45  
 (Date rec'd by registrar)

Registrar

20. DATE OF DEATH May 6<sup>th</sup> 1945 at 4 P. M.

I certify that death occurred on the date above stated; that I attended deceased from June 1944 to May 6 1945

and that I last saw her alive on May 6 1945

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Denton M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed 5/7/45

RECEIVED  
MAY 9 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County Caroline  
 City or town Greensboro Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Caroline  
 City or town Greensboro Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Lotta P. Cook

## 3. (b) Social Security Number

4. Sex F 5. Color or race w 6.(a) Single, married, widowed, or divorced married

## 6.(b) Name of husband or wife

Frank Cook

7. Birth date of deceased (mo., day, yr.) April 17, 1892 8.(c) If alive, give age 70 years

8. AGE: Years 63 Months 1 Days 6 It less than one day  
 hrs. min.

9. Birthplace Drewding Creek N. g.  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name Amos Pepper

13. Birthplace N. g.

14. Maiden name Mary P. Ayers

15. Birthplace N. g.

16. Informant Frank Cook

Address Greensboro Md.

17. Burial Date thereof May 26, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greensboro

Location Greensboro Md.

18. Funeral director Raymond B. Rawlins

Address Greensboro Md.

19. May 25 1945 S. M. Piggie  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1945 at 4-38 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

Due to Coronary Atherosclerosis Sudden

Due to Hypertension of 3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Anteopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel O. George

Address Denton Md. Date signed 5/29/45

RECEIVED

MAY 25 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

## CERTIFICATE OF DEATH

04837

Reg. Dist. No. 62

## 1. PLACE OF DEATH:

County... CAROLINE

City or town... DENTON, MD  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 MONTHS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

HATTIE E. DAVIS

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife THOS. F. DAVIS

6. (c) If alive, give age 72 years

7. Birth date of

deceased (mo., day, yr.)

Aug 1, 1876

8. AGE:

68

Years

9

Months

7

Days

If less than one day

hrs.

min.

9. Birthplace

ROCK HALL, MD.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

JAMES A. CASEY

13. Birthplace

MD

MOTHER

14. Maiden name

MARY K. COLEMAN

15. Birthplace

MD.

16. Informant

Mrs IRVIN &amp; SMITH.

Address

DENTON MD.

17. Burial, cremation, or removal. Which?

BURIAL

Date thereof MAY 11, 1945  
(month) (day) (year)

Cemetery or crematory

WESLEY CAPEL

Location

KENT CO. ROCK HALL MD.

19. Funeral director

J. WILLIS WELLS

Address

CHESTERTOWN, MD.

19. 5-9 1945  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MD.

County

KENT

City or town

ROCK HALL

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 8

1945

at

11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6

1945

to May 8

1945

and that I last saw him alive on

May 8

1945

Immediate cause of death

arterio-sclerosis -

DURATION

5 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

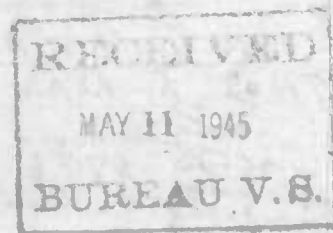
J. Paul (tho) MD

M. D. or other

Address

Denton MD

Date signed 5/9/45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

## CERTIFICATE OF DEATH

04838

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County Caroline  
 City or town Federalburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 35 years  
 Hospital, institution, or street address where death occurred:  
Reliance Avenue  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline  
 City or town Federalburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Reliance Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

Harvey Evans

## 3. (b) Social Security Number

213-03-9675

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Edith V. Evans6. (c) If alive, give age - years

## 7. Birth date of

deceased (mo., day, yr.)

November 16, 1872

## 8. AGE:

Years

72

Months

5

Days

21

If less than one day

- hrs. - min.

## 9. Birthplace

Caroline County, Maryland  
(Town, county, and state)

## 10. Usual occupation

Retired Day Laborer

## 11. Industry or business

Poultry & Egg Concentrator

## FATHER

## 12. Name

David R. Evans

## 13. Birthplace

Caroline County, Maryland

## MOTHER

## 14. Maiden name

Mary Elizabeth Bland

## 15. Birthplace

Talbot County, Maryland

## 16. Informant

Mrs. Hattie Woodward

## Address

Federalburg, Maryland

## 17.

(Burial, cremation, or removal, Which?)

Burial

## Date thereof

May 10, 1945

(month) (day) (year)

## Cemetery or crematory

Hill Crest Cemetery

## Location

Federalburg, Maryland

## 18. Funeral director

J. J. Frampton and Son

## Address

Federalburg, Maryland

## 19.

May 9, 1945  
(Date received by registrar)J. J. Frampton  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1945 at 11 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1943 to May 7, 1945and that I last saw him alive on May 7, 1945Immediate cause of death Coronary Thrombosis 12 hrs.

## DURATION

Chronic myocarditis 3 yrs.HypertensionDue to Chronic myocarditis 3 yrs.Due to HypertensionOther conditions -

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. -

## Autopsy results

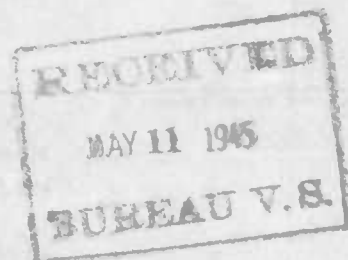
PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -

## 23. SIGNATURE

Frank M. Anderson  
Federalburg, Md. M. D.Address - Date signed 5/8/45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

04839

Reg. Diat. No. 62

## 1. PLACE OF DEATH:

County... CarolineCity or town... Denton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD County... CarolineCity or town... Denton  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

No name

## 3. (b) Social Security Number

Flamer

4. Sex

Female

5. Color or race

Col

6.(a) Single, married, widowed, or divorced

Single

## MEDICAL CERTIFICATION

2D. DATE OF DEATH... May 10 19 45 at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

DURATION

Due to.....

Premature Birth7 mos

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed 11/1/45

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of  
deceased (mo., day, yr.)May 8, 1945

8. AGE:

Years

Months

Days

If less than one day

2

hrs.

min.

11. Industry or business.....

FATHER

12. Name

Rowley Flamer

13. Birthplace

Maryland

MOTHER

14. Maiden name

Elsie Stephens

15. Birthplace

Maryland

16. Informant

Lellie Duff

Address

Denton MD

17.

(Burial, cremation, or removal. Which?)

Date thereof... 5-11-45  
(month) (day) (year)

Cemetery or crematory

Spring Creek Cemetery

Location

Denton MD

18. Funeral director

J. Emil Hancock

Address

Denton MD

19.

(Date rec'd by registrar)

19 45MD George

Registrar

RECEIVED  
JAN 14 1945  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of year of birth is shown on

FILM NO. G 96 JUN 21 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 64

### 1. PLACE OF DEATH:

County... Caroline

City or town... Federalburg, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

102 Oakley Ave.

How long in hospital or institution? 6 wks

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town...  
(If outside city or town limits, write RURAL and give nearest town)

Street No...  
(If rural, give LOCATION)

2.(a) If veteran, name war... no

### 3. (a) FULL NAME

Wm. R. Goslin

### 3. (b) Social Security Number

no

4. Sex M. 5. Color or race white 6.(a) Single, married, widowed, or divorced married

8.(b) Name of husband or wife Carrie E. Goslin

7. Birth date of deceased (mo., day, yr.) December 28, 1866 1867

8. AGE: Years 77 Months 5 Days 2 If less than one day

9. Birthplace Federalburg, Md.  
(Town, county and state)

10. Usual occupation... retired

11. Industry or business "

12. Name Thomas H. Goslin

13. Birthplace Federalburg, Md.

14. Maiden name Isabelle Carey

15. Birthplace Federalburg, Md.

16. Informant Mrs. Carrie Goslin

Address Federalburg, Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof June 1, 1945

Cemetery or crematory St. Paul's Cemetery

Location Federalburg, Md.

18. Funeral director H. H. Williams

Address Federalburg, Md.

19. June 1, 1945 (Date rec'd by registrar)

Registrar J. J. Garrison

Deputy Registrar J. J. Garrison

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1945 to May 30, 1945

and that I last saw him alive on May 30, 1945

Immediate cause of death Coronary thrombosis

Other conditions... no

Major findings of operations... no

Autopsy results... no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank M. Anderson

Address Federalburg, Md.

Date signed 5/31/45

RECEIVED  
JUN 9 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

04841 T

FILM No G 95 MAY 21 1945

## CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH: Caroline  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 years  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....MD. County.....Caroline.  
City or town.....Summersburg Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME Robert E. Jones.

3. (b) Social Security Number 213-14-4522

4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced Single.

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Nov. 17 1913 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day  
31 -32 6- 24 hrs. min.

9. Birthplace Summersburg Caroline Md  
(Town, county, and state)

10. Usual occupation Lawyer

11. Industry or business State Road.

12. Name Robert E. Jones.

13. Birthplace Md.

14. Maiden name Ruth E. Jones.

15. Birthplace Md.

16. Informant Harry Jones.

Address Summersburg Md.

17. (Burial, cremation, or removal) Washed Date thereof May 13 1945  
(month) (day) (year)

Cemetery or crematory Summersburg Md.

Location Summersburg Md.

18. Funeral director Raymond B. Rawlings

Address Summersburg Md.

19. May 12 1945 Registrar L. M. Pappas  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1945 at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death..... DURATION

Due to Gun shot wound of head

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 5-9-45

Where did injury occur? Summersburg Caroline Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury Gun shot wound Injured at work? no

23. SIGNATURE Amos O. George - es -

Address Benton Md M. D. or other

Date signed 5/10/45

RECEIVED  
MAY 14 1945  
BUREAU V.S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

## CERTIFICATE OF DEATH

04842

Reg. Dist. No. 64

## 1. PLACE OF DEATH:

County Caroline  
 City or town Federalburg - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:  
Smithville Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Federalburg - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Smithville Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Sallie M. Nabb

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Tristram D. Nabb  
 6.(c) If alive, give age 72 years  
 7. Birth date of deceased (mo., day, yr.) June 28, 1876  
 8. AGE: Years 68 Months 10 Days 17 It less than one day  
 hrs. min.

9. Birthplace Dorchester County, Maryland  
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

12. Name Samuel Corkran

13. Birthplace Dorchester County, Maryland

14. Maiden name Mary E. Harper

15. Birthplace Dorchester County, Maryland

16. Informant Tristram D. Nabb

Address Federalburg, Maryland, R.F.D.

17. Burial Date thereof May 17, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory East New Market Cemetery

Location East New Market, Maryland

18. Funeral director J. J. Frampton & Son

Address Federalburg, Maryland

19. May 17 19 45 S. J. Frampton  
 (Date reg'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 19 45, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 15 19 45 to May 15 19 45.

and that I last saw her alive on May 15 19 45.

Immediate cause of death Cosmery Abscess DURATION 4 hrs.

Due to Chronic pyococcalitis 5 yrs

Hypertension 3 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank M. Anderson M.D. M. D. or other

Federalburg, Md Date signed 5/17/45



RECEIVED

MAY 19 1945

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04843

Reg. Dist. No. 61

## 1. PLACE OF DEATH:

County Caroline  
 City or town Greensboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Caroline  
 City or town Greensboro  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(n) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

George H. Nashold

## 3. (b) Social Security Number

4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced married  
 8. (b) Name of husband or wife Aura Nashold  
 7. Birth date of deceased (mo., day, yr.) Sept 5, 1888 8. (c) If alive, give age 48 years  
 8. AGE: Years 5-6 Months 7 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wausau, Wis  
 (Town, county, and state)

10. Usual occupation Trucker

11. Industry or business Produce

12. Name George Nashold

13. Birthplace Wis

14. Maiden name Mary Stone

15. Birthplace Wis

16. Informant Mary Bowman

Address Greensboro md

17. Burial Date thereof May 8, 45  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Greensboro

Location Greensboro md

16. Funeral director Raymond B. Rawlings

Address Greensboro md

May 7 19 45 S. M. Lippin  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 45 st. 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 24 19 44 to May 2 19 45

and that I last saw him alive on May 1 19 45

Immediate cause of death Coronary Artery Disease

with hypertension & anemia

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Coronary Disease

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles H. Lippin

Address Greensboro md Date signed May 7, 1945

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
MAY 8 1945  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 63

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Cora Fisher Noble

## 3.(b) Social Security Number

4. Sex.....  
 5. Color or race.....  
 6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....  
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....  
 11. Industry or business.....

12. Name.....  
 13. Birthplace.....

14. Maiden name.....  
 15. Birthplace.....

16. Informant.....  
 Address.....

17. Burial.....  
 (Burial, cremation, or removal. Which?).....  
 Cemetery or crematory.....  
 Location.....

18. Funeral director.....  
 Address.....

19. May 31, 1945.....  
 (Date rec'd by registrar).....

20. Date of death.....  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
 and that I last saw him alive on.....  
 Immediate cause of death.....  
 Infection.....

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide.....  
 Where did injury occur?.....  
 (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury.....  
 Injured at work?.....

23. SIGNATURE.....  
 Address.....  
 Date signed.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
 and that I last saw him alive on.....  
 Immediate cause of death.....  
 Infection.....

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide.....  
 Where did injury occur?.....  
 (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury.....  
 Injured at work?.....

23. SIGNATURE.....  
 Address.....  
 Date signed.....

24. SIGNATURE.....  
 Address.....  
 Date signed.....

25. SIGNATURE.....  
 Address.....  
 Date signed.....

26. SIGNATURE.....  
 Address.....  
 Date signed.....

27. SIGNATURE.....  
 Address.....  
 Date signed.....

28. SIGNATURE.....  
 Address.....  
 Date signed.....

29. SIGNATURE.....  
 Address.....  
 Date signed.....

30. SIGNATURE.....  
 Address.....  
 Date signed.....

31. SIGNATURE.....  
 Address.....  
 Date signed.....

32. SIGNATURE.....  
 Address.....  
 Date signed.....

33. SIGNATURE.....  
 Address.....  
 Date signed.....

34. SIGNATURE.....  
 Address.....  
 Date signed.....

RECEIVED  
JUN 4 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04845

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County CarolineCity or town Shenandoah Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty CarolineCity or town Shenandoah Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Anna Patinau

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

B

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

George Patinau

7. Birth date of

deceased (mo., day, yr.)

Sept 1962

6.(c) If alive, give age

years

8. AGE:

Years

Months

Days

It less than one day

92

hrs.

min.

9. Birthplace

Shenandoah Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

MOTHER FATHER

12. Name

John Johnson

13. Birthplace

Md.

14. Maiden name

Anna Howard

15. Birthplace

Md.

16. Informant

Address

John Johnson  
Shenandoah Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 9. 45  
(month) (day) (year)

Cemetery or crematory

Union

Location

Near Shenandoah Md.

18. Funeral director

Address

Raymond B. Rawlins  
Shenandoah Md.

19.

(Date rec'd by registrar)

May 7 1945  
R. M. Pizzini  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 619 45, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

March 119 45to May 619 45

and that I last saw him alive on

May 519 45

Immediate cause of death

Chronic Refractive  
not insured

DURATION

Due to

Chronic Refractive  
not insured

Due to

Chronic Refractive  
not insured

Other conditions

Acute Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Gail H. Howard  
Shenandoah Md.

M. D. or other

Address

Date signed

May 7 1945

CERTIFICATE OF DEATH

RECEIVED  
MAY 8 1945  
BUREAU V.I.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9409

## CERTIFICATE OF DEATH

Reg. Dist. No. 66

## 1. PLACE OF DEATH:

County Caroline  
 City or town Ridgely  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Caroline  
 City or town Ridgely  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Central Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

David Mulford Seving  
 4. Sex m. 5. Color or race co. 6. (a) Single, married, widowed, or divorced Married

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 27 1945 at 12:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 19 1945 to May 27 1945  
 and that I last saw him alive on May 26 1945

Immediate cause of death Coronary Thrombosis DURATION 7 hrs.

Due to arteriosclerosis  
& Coronary sclerosis years

Due to Deafness years  
 Other conditions Deafness Chronic  
 (Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op. ....

Autopsy results ✓  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide. Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE W. J. Seving M.D.  
 Address Ridgely, Md. Date signed 5-28-45

6. (b) Name of husband or wife Hila Thompson Seving

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1866  
 6. (c) If alive, give age 78 years

8. AGE: Years Months Days If less than one day  
78 6 46 ....hrs. ....min.

9. Birthplace Bridgeton, N.J.  
 (Town, county, and state)

10. Usual occupation Petrol Canner

11. Industry or business

12. Name Michael H. Seving  
 13. Birthplace N. J.

14. Maiden name Elena Mulford  
 15. Birthplace N. J.

18. Informant Thompson Seving  
 Address Ridgely, Md.

17. Burial, cremation, or removal Which? Burial Date thereof May 28, 1945  
 (month) (day) (year)

Cemetery or crematory Denton  
 Location Denton, Md.

18. Funeral director Reis Church  
 Address Denton, Md.

19. May 28 1945 J. D. Davis  
 (Date rec'd by registrar) Registrar

RECEIVED  
MAY 31 1945  
BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

04847

Reg. Dist. No. 61

1. PLACE OF DEATH: *Caroline*  
 County.....  
 City or town..... *Greensboro Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... *2 years*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... *md* County..... *Caroline*  
 City or town..... *Greensboro Rural*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)

3. (a) FULL NAME *Mary E. Thomas*

3. (b) Social Security Number

4. Sex *F* 5. Color or race *C* 6. (a) Single, married, widowed, or divorced *Widowed*  
 6. (b) Name of husband or wife..... *William Thomas*  
 7. Birth date of deceased (mo., day, yr.) *May 1, 1875* 6. (c) If alive, give age..... years  
 8. AGE: Years *70* Months *8* Days *8* If less than one day..... hrs. .... min.

9. Birthplace..... *Greensboro Caroline Md.*  
 (Town, county, and state)  
 10. Usual occupation..... *Housewife*

11. Industry or business  
 12. Name..... *Alexander Homed*  
 13. Birthplace..... *md*  
 14. Maiden name..... *Mary Bee*  
 15. Birthplace..... *md*

16. Informant..... *James Johnson*  
 Address..... *Greensboro md*  
 17. *Burial* (Burial, cremation, or removal. Which?) Date thereof..... *May 12, 1945*  
 (month) (day) (year)  
 Cemetery or crematory..... *Union*  
 Location..... *Near Greensboro Md.*

16. Funeral director..... *Raymond B. Hawlings*  
 Address..... *Greensboro Md.*

19. *May 10 1945* (Date rec'd by registrar) *L. M. Lippin* Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *May 9* 19... *45*, at *7 P.* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Mar 5* 19... *45* to *May 9* 19... *45*  
 and that I last saw him alive on *May 8* 19... *45*

Immediate cause of death..... *Coronary Atherosclerosis* DURATION *1 WK*

Due to..... *Coronary Atherosclerosis*

Due to..... *Coronary Atherosclerosis*

Other conditions..... *Chronic Bronchitis* DURATION *2 Wks*

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of Injury..... Injured at work?

23. SIGNATURE..... *Charles H. Thomas* M. D. of *Greensboro Md*  
 Address..... Date signed..... *May 10 1945*

RECEIVED  
MAY 12 1945  
BUREAU

RECEIVED  
MAY 12 1945  
BUREAU